		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0034991

Facility Name: PARK HOUSE

Address: 2320 SOUTH LAWNDALE (Number) CHICAGO (City) 60623 (Zip Code)

County: COOK

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3620976

Date of Initial License for Current Owners: 01/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,110	1
2		Skilled Pediatric (SNF/PED)			2
3	92	Intermediate (ICF)	92	33,580	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	106	TOTALS	106	38,690	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,059	4,059	8
9	SNF/PED					9
10	ICF	29,459	1,308		30,767	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,459	1,308	4,059	34,826	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.01%

D. How many bed-hold days during this year were paid by Public Aid?
835 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified _____ and days of care provided 4,059

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	152,891	13,301	7,379	173,571		173,571	1,402	174,973			1
2	Food Purchase		131,858		131,858	(12,483)	119,375	(415)	118,960			2
3	Housekeeping	101,738	21,916		123,654		123,654		123,654			3
4	Laundry	27,135	16,492		43,627		43,627		43,627			4
5	Heat and Other Utilities			71,384	71,384		71,384	133	71,517			5
6	Maintenance	16,156	22,518	27,581	66,255		66,255	5,649	71,904			6
7	Other (specify):*			11,202	11,202		11,202		11,202			7
8	**TOTAL General Services**	297,920	206,085	117,546	621,551	(12,483)	609,068	6,769	615,837			8
	B. Health Care and Programs											
9	Medical Director			8,500	8,500		8,500		8,500			9
10	Nursing and Medical Records	781,965	33,022	254,079	1,069,066		1,069,066	(231,158)	837,908			10
10a	Therapy	25,886	1,561	44,937	72,384		72,384	(2,950)	69,434			10a
11	Activities	58,751	11,577	2,064	72,392		72,392		72,392			11
12	Social Services	112,909		3,256	116,165		116,165		116,165			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	979,511	46,160	312,836	1,338,507		1,338,507	(234,108)	1,104,399			16
	C. General Administration											
17	Administrative	103,671		219,600	323,271		323,271	(178,537)	144,734			17
18	Directors Fees											18
19	Professional Services			280,525	280,525		280,525	(215,407)	65,118			19
20	Dues, Fees, Subscriptions & Promotions			21,152	21,152		21,152	1,795	22,947			20
21	Clerical & General Office Expenses	87,931	7,644	98,692	194,267		194,267	(11,833)	182,434			21
22	Employee Benefits & Payroll Taxes			252,154	252,154	12,483	264,637		264,637			22
23	Inservice Training & Education			1,337	1,337		1,337	554	1,891			23
24	Travel and Seminar							497	497			24
25	Other Admin. Staff Transportation			1,538	1,538		1,538	1,847	3,385			25
26	Insurance-Prop.Liab.Malpractice			41,882	41,882		41,882	1,926	43,808			26
27	Other (specify):*							27,347	27,347			27
28	**TOTAL General Administration**	191,602	7,644	916,880	1,116,126	12,483	1,128,609	(371,811)	756,798			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,469,033	259,889	1,347,262	3,076,184		3,076,184	(599,150)	2,477,034			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: PARK HOUSE **#0034991** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,000	
	REPAIRS & MAINTENANCE		1,379	
			0	7,379
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		29,013	
	ELECTRICITY		30,239	
	WATER		11,330	
	CABLE TV - LOBBY		802	
			0	71,384
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,389	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,579	
	ELEVATOR MAINTENANCE & REPAIR		6,438	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,705	
	FIRE SERVICE		5,470	
			0	
			0	
			0	27,581
7	**OTHER**			
	SCAVENGER		11,202	
	SECURITY SERVICE		0	11,202
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	8,500	8,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		189	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,064	
	PHARMACY CONSULTANT	XVIII B 39-2	631	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	100,000	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICES		195	
	MEDICARE/PUBIC AID		150,000	254,079
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		6,534	
	THERAPY CONTRACT SERVICES		20,340	
	OCCUPATIONAL THERAPY SERVICES		7,263	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	44,937
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,064	
			0	2,064
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	3,256	
			0	3,256
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PARK HOUSE **#0034991** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	219,600	219,600
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,252	
	ADMINISTRATIVE CONSULTANTS	XIX C	206,050	
	PROFESSIONAL FEES	XIX C	55,223	
			0	280,525
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	1,451	
	EMPLOYEE WANT ADS	XIX F	7,572	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	6,932	
	LICENSES & PERMITS	XIX F	3,889	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	1,308	21,152
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		6,292	
	OUTSIDE CLERICAL SERVICES		63,600	
	PENALTIES / OVERDRAFT CHARGES	VI 18	11,522	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		16,623	
	MESSENGER SERVICE		655	
			0	98,692

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	111,450	
	UNEMPLOYMENT COMPENSATION	XIX D	16,439	
	WORKERS COMPENSATION INSURANCI	XIX D	47,165	
	HOSPITALIZATION INSURANCE	XIX D	59,707	
	EMPLOYEE BENEFITS - OTHER	XIX D	13,793	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	3,600	252,154
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,337	1,337
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		1,538	1,538
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		41,882	41,882
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,347,262

Facility Name & ID Number PARK HOUSE #0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			30,956	30,956		30,956	47,683	78,639			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							239,195	239,195			32
33	Real Estate Taxes			74,942	74,942		74,942		74,942			33
34	Rent-Facility & Grounds			374,621	374,621		374,621	(368,267)	6,354			34
35	Rent-Equipment & Vehicles			13,991	13,991		13,991	4,921	18,912			35
36	Other (specify):*											36
37	**TOTAL Ownership**			494,510	494,510		494,510	(76,468)	418,042			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		116,533	256,254	372,787		372,787	(45,794)	326,993			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			58,035	58,035		58,035		58,035			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		116,533	314,289	430,822		430,822	(45,794)	385,028			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,469,033	376,422	2,156,061	4,001,516		4,001,516	(721,412)	3,280,104			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(3,241)	30		9
10	Interest and Other Investment Income	(59,847)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(415)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(11,522)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(1,451)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	466			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (76,010)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(645,402)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (645,402)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (721,412)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

PARK HOUSE

ID# 0034991

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 466	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	466		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(6,000)	7,402	0	0	0	0	0	0	0	0	1,402	1
2	Food Purchase	(415)	0	0	0	0	0	0	0	0	0	0	(415)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	133	0	0	0	0	0	0	0	0	133	5
6	Maintenance	466	0	5,183	0	0	0	0	0	0	0	0	5,649	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	51	(6,000)	12,718	0	0	0	0	0	0	0	0	6,769	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(250,000)	18,842	0	0	0	0	0	0	0	0	(231,158)	10
10a	Therapy	0	(8,031)	5,081	0	0	0	0	0	0	0	0	(2,950)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	(258,031)	23,923	0	0	0	0	0	0	0	0	(234,108)	16
	C. General Administration													
17	Administrative	0	(219,600)	41,063	0	0	0	0	0	0	0	0	(178,537)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(218,000)	2,593	0	0	0	0	0	0	0	0	(215,407)	19
20	Fees, Subscriptions & Promotions	(1,451)	0	3,246	0	0	0	0	0	0	0	0	1,795	20
21	Clerical & General Office Expenses	(11,522)	(63,600)	63,289	0	0	0	0	0	0	0	0	(11,833)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	554	0	0	0	0	0	0	0	0	554	23
24	Travel and Seminar	0	0	497	0	0	0	0	0	0	0	0	497	24
25	Other Admin. Staff Transportation	0	0	1,847	0	0	0	0	0	0	0	0	1,847	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,926	0	0	0	0	0	0	0	0	1,926	26
27	Other (specify):*	0	0	27,347	0	0	0	0	0	0	0	0	27,347	27
28	**TOTAL General Administration**	(12,973)	(501,200)	142,362	0	0	0	0	0	0	0	0	(371,811)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(12,922)	(765,231)	179,003	0	0	0	0	0	0	0	0	(599,150)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PARK HOUSE # 0034991 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(3,241)	43,465	7,459	0	0	0	0	0	0	0	0	47,683	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(59,847)	270,062	28,980	0	0	0	0	0	0	0	0	239,195	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(374,621)	6,354	0	0	0	0	0	0	0	0	(368,267)	34
35	Rent-Equipment & Vehicles	0	0	4,921	0	0	0	0	0	0	0	0	4,921	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(63,088)	(61,094)	47,714	0	0	0	0	0	0	0	0	(76,468)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(45,794)	0	0	0	0	0	0	0	0	0	(45,794)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	(45,794)	0	0	0	0	0	0	0	0	0	(45,794)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(76,010)	(872,119)	226,717	0	0	0	0	0	0	0	0	(721,412)	45

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		SCHEDULE ATTACHED		CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHABILITATIVE SERVICES		
					NILES	THERAPY
				2320 S LAWNDALE	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 374,621	2320 S LAWNDALE LLC		$	$ (374,621)	1
2	V	30	SL DEPRECIATION		" "		43,465	43,465	2
3	V	32	INTEREST		" "		270,062	270,062	3
4	V	10a	THERAPY SERVICES	44,937	CAREPLUS REHABILITATIVE SERVICES		36,906	(8,031)	4
5	V	39	ANCILLARY SERVICES	256,253	" " "		210,459	(45,794)	5
6	V	1	DIETARY CONSULTANT	6,000	CAREPLUS MGMT INC			(6,000)	6
7	V	10	MEIDCARE CONSULTANT	50,000	" " "			(50,000)	7
8	V	10	PUBLIC AID CONSULTANT	100,000	" " "			(100,000)	8
9	V	10	MENTAL HEALTH CONSULT	100,000	" " "			(100,000)	9
10	V	17	MANAGEMENT FEE	219,600	" " "			(219,600)	10
11	V	19	ADMIN CONSULTANT	206,000	" " "			(206,000)	11
12	V	19	DATA PROCESSING	12,000	" " "			(12,000)	12
13	V	21	CLERICAL FEES	63,600	" " "			(63,600)	13
14	Total			$ 1,433,011			$ 560,892	$ * (872,119)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SALARIES	$	CAREPLUS MGMT INC	100.00%	$ 7,402	$ 7,402	15
16	V	5	ELECTRICITY		" " "		133	133	16
17	V	6	MAINT & REPAIRS		" " "		227	227	17
18	V	6	MAINTENANCE SALARIES		" " "		4,956	4,956	18
19	V	10	NURSING SALARIES		" " "		18,842	18,842	19
20	V	10a	THERAPY SALARIES		" " "		5,081	5,081	20
21	V	17	ADMIN SALARIES		" " "		41,063	41,063	21
22	V	19	PROFESSIONAL FEES		" " "		2,593	2,593	22
23	V	20	ADVERTISING		" " "		3,246	3,246	23
24	V	21	OFFICE EXPENSE		" " "		16,271	16,271	24
25	V	21	OFFICE SALARIES		" " "		47,018	47,018	25
26	V	23	SEMINARS		" " "		554	554	26
27	V	24	TRAVEL		" " "		497	497	27
28	V	25	TRANSPORTATION		" " "		1,847	1,847	28
29	V	26	INSURANCE		" " "		1,926	1,926	29
30	V	27	EMPLOYEE BENEFITS		" " "		27,347	27,347	30
31	V	30	DEPRECIATION		" " "		7,459	7,459	31
32	V	32	INTEREST		" " "		28,980	28,980	32
33	V	34	OFFICE RENT		" " "		6,354	6,354	33
34	V	35	EQUIPMENT RENT		" " "		4,921	4,921	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 226,717	$ * 226,717	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	JAKOB BAKST	DIR OPERATIONS	ADMIN,CONSULT		SEE ATTACHED			SALARY	11,325	17-7	2
3	SHERWIN I RAY	PRESIDENT	ADMIN,FINANCE		SCHEDULE			SALARY	11,325	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,650		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT INC
Street Address: 5940 W TOUHY
City / State / Zip Code: NILES IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	PATIENT DAYS	568,908	13	$ 96,016	$ 96,016	34,826	$ 7,402	1
2	5	ELECTRICITY	PATIENT DAYS	568,908	13	2,165		34,826	133	2
3	6	MAINT & REPAIRS	PATIENT DAYS	568,908	13	3,701		34,826	227	3
4	6	MAINTENANCE SALARIES	PATIENT DAYS	568,908	13	80,966	80,966	34,826	4,956	4
5	10	NURSING SALARIES	PATIENT DAYS	568,908	13	307,794	307,794	34,826	18,842	5
6	10a	THERAPY SALARIES	PATIENT DAYS	568,908	13	82,996	82,996	34,826	5,081	6
7	17	ADMIN SALARIES	PATIENT DAYS	568,908	13	670,787	670,787	34,826	41,063	7
8	19	PROFESSIONAL FEES	PATIENT DAYS	568,908	13	42,352		34,826	2,593	8
9	20	ADVERTISING	PATIENT DAYS	568,908	13	53,021		34,826	3,246	9
10	21	OFFICE EXPENSE	PATIENT DAYS	568,908	13	265,794		34,826	16,271	10
11	21	OFFICE SALARIES	PATIENT DAYS	568,908	13	768,069	768,069	34,826	47,018	11
12	23	SEMINARS	PATIENT DAYS	568,908	13	9,053		34,826	554	12
13	24	TRAVEL	PATIENT DAYS	568,908	13	8,124		34,826	497	13
14	25	TRANSPORTATION	PATIENT DAYS	568,908	13	30,176		34,826	1,847	14
15	26	INSURANCE	PATIENT DAYS	568,908	13	31,470		34,826	1,926	15
16	27	EMPLOYEE BENEFITS	PATIENT DAYS	568,908	13	446,737		34,826	27,347	16
17	30	DEPRECIATION	PATIENT DAYS	568,908	13	121,842		34,826	7,459	17
18	32	INTEREST	PATIENT DAYS	568,908	13	473,414		34,826	28,980	18
19	34	OFFICE RENT	PATIENT DAYS	568,908	13	103,790		34,826	6,354	19
20	35	EQUIPMENT RENT	PATIENT DAYS	568,908	13	80,391		34,826	4,921	20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,678,658	$ 2,006,628		$ 226,717	25

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: 2320 S LAWNDALE LLC						$	$			$	1
2	NOMURA		X	MORTGAGE	$26,467.97	12/95	3,185,096		11/10/07	9.2500	256,010	2
3												3
4	CAREPLUS MANAGEMENT	X		CAPITAL IMPRV LOAN							14,052	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$26,467.97		$ 3,185,096	$			$ 270,062	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,185,096	$			$ 270,062	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 74,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 73,742	2
3. Under or (over) accrual (line 2 minus line 1).		$ (658)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 75,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 74,942	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	63,583	8
1999	63,156	9
2000	71,075	10
2001	72,924	11
2002	73,742	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PARK HOUSE COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0034991

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	16-26-105-075-0000	NURSING HOME	$ 31,882.79	$ 31,882.79
2.	16-26-105-080-0000	NURSING HOME	$ 20,968.68	$ 20,968.68
3.	16-26-105-079-0000	NURSING HOME	$ 20,890.16	$ 20,890.16
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,741.63	$ 73,741.63

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,849 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,000	1995	$ 100,000	1
2					2
3	TOTALS	51,000		$ 100,000	3

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5	106		1989		1,209,350	38,397	39	38,397		574,346	5
6											6
7											7
8						72		72			8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1989	17,739	563	20	887	324	12,659	9
10	LEASEHOLD IMPROVEMENTS			1989	4,204	280	15	280		4,130	10
11	LEASEHOLD IMPROVEMENTS			1990	11,700	371	20	585	214	7,794	11
12	LEASEHOLD IMPROVEMENTS			1991	17,413	553	20	871	318	10,887	12
13	LEASEHOLD IMPROVEMENTS			1992	55,138	1,858	31.5	1,750	(108)	20,446	13
14	LEASEHOLD IMPROVEMENTS			1993	26,399	748	31.5	838	90	8,799	14
15	LEASEHOLD IMPROVEMENTS			1994	3,400	87	39	87		852	15
16	ROOF REPAIR			1995	1,500	38	39	38		325	16
17	ROOF-TOP HEAT/A/C			1996	10,000	256	39	256		2,017	17
18	CEILING TILE/DUMBWAITER REPAIR			1996	12,253	314	39	314		2,395	18
19	RE-ROOF			1996	80,861	2,073	39	2,073		15,200	19
20	FIXTURES/WINDOWS			1996	3,850	99	39	99		712	20
21	WINDOWS			1997	18,900	485	39	485		3,070	21
22	ROOF REPAIR & ROOF-TOP HEAT/A/C INSTALLATION			1997	3,228	83	39	83		537	22
23	DOOR & FLOORING			1997	2,922	75	39	75		491	23
24	ELEVATOR REPAIR			1997	3,125	80	39	80		510	24
25	WINDOWS			1998	12,600	323	39	323		1,858	25
26	TILE & FLOORING			1998	23,810	610	39	610		3,497	26
27	ELECTRICAL, PLUMBING AND ELEVATOR REPAIR			1998	31,238	801	39	801		4,514	27
28	NEW NURSE STATIONS			1998	24,271	622	39	622		3,655	28
29	WINDOW TREATMENTS AND BRAILLE SIGNS			1998	3,478	89	39	89		508	29
30	FIRE SYSTEM UPGRADE AND DAMPERS			1998	8,833	226	39	226		1,208	30
31	REAR PARKING LOT REPAIRS			1998	10,550	703	15	703		3,870	31
32	WINDOWS/CLOSETS/OUTLETS/DUMBWAITER/ROOF			1999	23,174	594	39	594		2,797	32
33	ROOF REPAIR			1999	18,365	471	39	471		2,139	33
34	FRONT RAMP REPAIR			2000	1,200	44	27.5	44		118	34
35	VINYL TILE/KITCHEN			2000	6,213	226	27.5	226		782	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	DUMBWAITER REPAIR	2001	$ 3,264	$ 119	27.5	$ 119	$	$ 332	37
38	SIDEWALK/TUCKPOINTING	2001	5,500	367	15	367		917	38
39	KEYPAD ENTRY SYSTEM	2001	3,800	138	27.5	138		293	39
40	BOILER	2002	5,229	190	27.5	190		277	40
41	AC UNITS	2002	6,365	231	27.5	231		337	41
42	FLOORING	2002	2,328	85	27.5	85		124	42
43	FIRE PUMP REPAIR	2003	1,750	29	27.5	29		29	43
44	ELECTRICAL TO ROOFTOP UNIT	2003	1,951	33	27.5	33		33	44
45	PAINTING	2003	20,800	347	27.5	347		347	45
46	CEILING & DOOR REPAIRS	2003	1,180	20	27.5	20		20	46
47	CONCRETE REPAIRS	2003	2,961	50	27.5	50		50	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,700,842	$ 52,750		$ 53,588	$ 838	$ 692,875	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 182,781	$ 19,382	$ 17,434	$ (1,948)		$ (267,683)	71
72	Current Year Purchases	4,600	2,361	230	(2,131)		230	72
73	Fully Depreciated Assets	89,112					89,112	73
74	RELATED PARTY		7,387	7,387				74
75	TOTALS	$ 276,493	$ 29,130	$ 25,051	$ (4,079)		$ (178,341)	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,077,335	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 81,880	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 78,639	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (3,241)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 514,534	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 13,991 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 185,842	$		$ 185,842	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			70,412			70,412	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				113,051		113,051	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): LAB/MED SUPP	39-2 & 3					3,482		3,482	13
14	TOTAL			$		$ 256,254	$ 116,533		$ 372,787	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 55,000)	2,099,611		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,078		6
7	Other Prepaid Expenses	22,042		7
8	Accounts Receivable (owners or related parties)	660,000		8
9	Other(specify): RE TAX ESCROW	68,942		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,862,673	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	331,746		15
16	Equipment, at Historical Cost	276,495		16
17	Accumulated Depreciation (book methods)	(288,530)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): REPLACEMENT RESERVE	70,117		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 389,828	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,252,501	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 480,375	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	78,720		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,620		31
32	Accrued Real Estate Taxes(Sch.IX-B)	75,600		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 641,315	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	60,128		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 60,128	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 701,443	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,551,058	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,252,501	$	48

*(See instructions.)

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,848,393	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,848,393	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	702,665	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 702,665	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,551,058	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,634,334	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,634,334	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	10,000	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 10,000	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	59,847	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 59,847	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,704,181	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	621,551	31
32	Health Care	1,338,507	32
33	General Administration	1,116,126	33
	B. Capital Expense		
34	Ownership	494,510	34
	C. Ancillary Expense		
35	Special Cost Centers	372,787	35
36	Provider Participation Fee	58,035	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,001,516	40
41	**Income before Income Taxes (line 30 minus line 40)****	702,665	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 702,665	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,376	2,874	$ 61,708	$ 21.47	1
2	Assistant Director of Nursing	750	806	18,039	22.38	2
3	Registered Nurses	2,019	2,035	49,322	24.24	3
4	Licensed Practical Nurses	11,257	11,463	242,439	21.15	4
5	Nurse Aides & Orderlies	42,149	45,883	393,657	8.58	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,913	2,165	25,886	11.96	8
9	Activity Director	1,884	1,959	28,317	14.45	9
10	Activity Assistants	3,827	4,014	30,434	7.58	10
11	Social Service Workers	6,919	7,363	112,909	15.33	11
12	Dietician					12
13	Food Service Supervisor	2,010	2,201	31,538	14.33	13
14	Head Cook					14
15	Cook Helpers/Assistants	13,657	14,900	121,353	8.14	15
16	Dishwashers					16
17	Maintenance Workers	1,730	1,826	16,156	8.85	17
18	Housekeepers	11,661	12,882	101,738	7.90	18
19	Laundry	2,954	3,292	27,135	8.24	19
20	Administrator	1,976	2,080	44,209	21.25	20
21	Assistant Administrator	1,944	2,072	59,462	28.70	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,592	7,199	87,931	12.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,946	1,991	16,800	8.44	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	117,564	127,005	$ 1,469,033 *	$ 11.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,000	1-3	35
36	Medical Director	O	8,500	9-3	36
37	Medical Records Consultant	N	3,064	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	631	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,064	11-3	44
45	Social Service Consultant	E	3,256	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 34,315		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
CALLIE GRAHAM	ADMIN	0	$ 44,209
PATRICIA L WILLIAMS-SMITH	ASST ADMIN	0	59,462
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 103,671

B. Administrative - Other

Description	Amount
CARE PLUS - MANAGEMENT FEES	$ 219,600
TOTAL (agree to Schedule V, line 17, col. 3)	$ 219,600
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		280,525
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 280,525

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 47,165
Unemployment Compensation Insurance		16,439
FICA Taxes		111,450
Employee Health Insurance		59,707
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		13,793
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		3,600
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,572
Health Care Worker Background Check	1,308
(Indicate # of checks performed 109)	
MARKETING/ADV/PROMO	1,451
TRUST/FRANCHISE/CONTRIB/ETC	0
LICENSES & PERMITS	3,889
DUES & SUBSCRIPTIONS	6,932
MGMT CO ALLOCATION	3,246
TRUST/FRANCHISE/CONTRIB/ETC	0
Less: Public Relations Expense	(0)
Non-allowable advertising	(1,451)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 22,947

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
RELATED PARTY	497
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 497

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAINTING/DECORATIN	2000	$ 2,797		$ 467	$ 932	$ 932	$ 466	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,797		$ 467	$ 932	$ 932	$ 466	$	$	$	$	$

Facility Name & ID Number PARK HOUSE # 0034991 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $5,724**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **167** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **58,035**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees